St. Bartholomew's Hospital

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

JOURNAL.

VOL. XLII.—No. 10.] JULY 1ST, 1935. PRICE NINEPENCE.

CALENDAR.

Mon., July 1.—Special Subjects: Lecture by Mr. Higgs.

Tues., „ 2.—Lord Horder and Sir Charles Gordon-Watson on duty.

Wed., „ 3.—Surgery: Clinical Lecture by Mr. Roberts.
Tennis Match *v.* R.N.C. Greenwich. Home.

Fri., „ 5.—Dr. Hinds Howell and Mr. Wilson on duty.

Sat., „ 6.—Cricket Match *v.* Blackheath. Home.
Tennis Match *v.* London School of Economics. Home.

Mon., „ 8.—Special Subjects: Lecture by Mr. Scott.

Tues., „ 9.—Dr. Gow and Mr. Girling Ball on duty.

Wed., „ 10.—Surgery: Clinical Lecture by Mr. Roberts.

Fri., „ 12.—Dr. Graham and Mr. Roberts on duty.

Sat., „ 13.—Cricket Match *v.* Shoeburyness. Away.
Tennis Match *v.* Guy's Hospital. Home.

Tues., „ 16.—Prof. Witts and Prof. Gask on duty.

Wed., „ 17.—Cricket Match *v.* St. Ann's. Away.

Fri., „ 19.—Lord Horder and Sir Charles Gordon-Watson on duty.

Last day for receiving matter for the August issue of the Journal.

Sat., „ 20.—Cricket Match *v.* Metropolitan Police. Away.
Tennis Match *v.* Staff College, Camberley. Home.

Tues., „ 23.—Dr. Hinds Howell and Mr. Wilson on duty.

Thurs., „ 25.—Cricket Match *v.* Midhurst. Away.

Fri., „ 26.—Dr. Gow and Mr. Girling Ball on duty.

Sat., „ 27.—Tennis Match *v.* Bank of England. Home.

Tues., „ 30.—Dr. Graham and Mr. Roberts on duty.

Wed., „ 31.—Cricket Match *v.* Hornsey. Away.

EDITORIAL.

THE old and familiar sight of the Medical Block on the south side of the Square rapidly fades before us, and in a matter of ten weeks will be razed to the ground by the efforts of the demolition gang. Unlike so many of their colleagues these iconoclasts—for iconoclasts unwittingly they are—pursue their end seven days out of seven, and the Square is no longer what it used to be at least on one day in the week. In place of the quiet, we have the unceasing clatter of falling masonry, one dust-storm after another, one cataclysm upon another; and now not even the Entrance remains, and we are forced to take a *détour* among builders' hoardings, which has as its only consolation the provision of an excuse, however thin, for arriving a little later than usual in the morning.

But though the old Medical Block is disappearing, it is pleasing to know that the stone of the facing is to be kept for its successor. The Square will preserve its integrity and we can think with Mr. Hardcastle, "I love everything that's old; old friends, old times, old manners, old books, old wine"—and old buildings too.

As the buildings, so the activities within them, and as we go to press we learn of a new scheme to be put into operation in October, whereby medical and surgical firms are to be made up of first or second three months clerks or dressers only. It is only an experiment, it must be added, but its advantages are self-evident and it may well be established in time as a valuable modification of the present day scheme.

* * *

When, as Dean of the Faculty, Prof. Gask, in the 1931–2 session, asked the Board of the Faculty of Medicine of London University to consider a review of the whole medical curriculum, it was hoped that at last bold reforms would be proposed. The Report of the Conference just issued justifies those hopes, and every

aspect of the problem has been inspected and criticized. The Conference included as representatives Sir Walter Langdon Brown (University of Cambridge), Sir Holburt Waring (Royal College of Surgeons of England), and Prof. Gask, representing the University of London. The last-named was chosen as Vice-Chairman of the Executive Committee.

The theme of the Report is the closer relation of the training of the doctor to his future needs, that it should be governed by those needs rather than by the temporary requirements of the Examiners. It admits that the general efficiency of the ordinary doctor is, in spite of, rather than because of, the present system of education. There is, however, no adequate means of discovering the type that is most suitably equipped by Providence for the practice of healing, of assessing the individual's share of those qualities of temperament, personality and intelligence which are as essential as the knowledge which the curriculum provides. The evils of the examination system are recognized, for they are at best a poor test of capability, and begotten of circumstances which some future Utopia may eliminate. At present they so often prove a strait gate for the intelligent but nervous student, and a broad way for the slacker with a facile and bold manner. They are the chief cause for the neglect of Sydenham's great maxim, " Our art is not better learnt than by its exercise and use ". They drive the most conscientious student from the bedside study of the body and mind in health and disease to the monotonous, soul-destroying perusal of text-books and synopses on the library table, where the most fascinating work becomes a weariness to the flesh and uneffective in practice. From the study of medicine as a whole there tends to be a division into water-tight compartments. " This very real defect can be overcome by reducing the number of examinations, and by making the transition from one course of instruction to the next as little abrupt as possible."

There must have been a temptation to be deaf to the demand for a man of culture, when so many facts of a purely scientific kind have to be imparted in so short a period of study. Such a step would tend to produce a scientific, perhaps intelligent robot, quite incapable of dealing with his patients as souls housed in a diseased body. " It has been somewhere said that the British doctor excels in practice rather than in science; it is true that most of our great figures in medicine—Sydenham, Hunter, Radcliffe, Jenner, Bright—have been great practitioners, but a few of them only have been men of science. They were, however, the outstanding figures of a common type, and have shown a sanity and breadth of outlook, a directness in method and a skill in action which have made a lasting name for their art." (We quote from that most instructive and thoughtful exposition of the ideals and principles of medical practice, *The Physician's Art*, by Dr. A. G. Gibson.) The Report therefore recommends a liberal education in the would-be medical student, and discourages specialization before the age of eighteen. The commendable and recent introduction of the preliminary sciences to the ordinary school teaching makes this possible, and the scholar is encouraged to obtain exemption from the pre-medical examination by means of a higher school certificate examination in those subjects and another of a non-scientific nature.

In the five years which the student is to spend in pre-clinical and clinical work the Conference has removed the present discrepancy in the time devoted to each part. The elements of pathology and medical psychology are to be added to the two-years' pre-clinical period, with the sacrifice of the burdensome and irrelevant detail at present demanded of the examination candidate. In anatomy, having finished his part with a knowledge sufficient for a " viva " before proceeding to the next, the student need remember only the broad principles of structure, always in close relation to what he has learnt in physiology. In the latter subject a better adaptation is recommended, more time being spent on those instruments and procedures which have a practical rather than an academic interest. This will counteract the tendency, less marked in this school than in most, to make each student a physiologist or a biochemist, and remove the cause of the universal complaint expressed by Lord Horder two years ago: " A great deal of my time in the wards is taken up in teaching first-time clerks these physiological methods. This should not be the best use that can be made of a physician who is supposed to be experienced in clinical methods and in the arts of diagnosis and treatment. And almost the whole of the work in the class which is variously called ' Auscultation and Percussion ', or ' Physical Methods ', or whatever other name it goes by, is really the province of the physiological class-room. It is so with the urine examination, and with blood examinations." Pharmacology, with toxicology, is also to be taught in this period, but examination deferred until " finals ". The pre-clinical studies cover two years.

In the clinical period less time is to be spent in studying rare diseases and watching tedious major operations, which are provided for in the courses for the higher examinations. Instead, opportunities should be provided for acquiring an intimate knowledge of the common minor ailments, including the neuroses and psychoneuroses, which play such a large part in a modern practice. Emphasis is laid on the teaching of preventive and psychological medicine in relation to

the ordinary hospital patients rather than as special subjects. Pathology should be taught throughout the curriculum, and be included in the final clinical examination. The final examination should consist of two parts, the first to be passed before he can be passed in the second, though both may be taken together. The Conference does not think that the average student is able to do himself justice in so stern a test as taking all the subjects together, however desirable that might be theoretically. Part II consists of obstetrics, gynæcology and pediatrics, and includes public health, forensic and State medicine, pathology, medicine and surgery being taken in the first part. The importance of obstetrics is emphasized because "the modern conditions of practice make the recently-qualified practitioner a consultant". It is urged that teachers of the special departments, such as those dealing with the organs of special sense, should be represented on the examining board, because the attention paid to these subjects is disproportionate to the very big part played by the disorders in general practice.

Finally, it is recommended that every student should have an appointment of at least six months' duration as a resident medical officer in an approved hospital. The number of such posts, it is hoped, will soon be sufficient to make the obligation statutory.

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We congratulate Dr. John Beattie on his appointment as Assistant Physician-Accoucheur.

* * *

Mr. Boyle has been elected as the first examiner for the Diploma of Anæsthetics of the Conjoint Board.

* * *

Dr. Denny Brown has been appointed as Chief Assistant to the Consultative Neurological Clinic.

* * *

Mr. Raven has been appointed Assistant Surgeon to the Gordon Hospital for Diseases of the Rectum.

* * *

In another column attention is drawn to the extraordinary feat of G. W. Hayward, who gained the Gold Medal in the London M.B. with distinction in all five subjects. We offer him our heartiest congratulations on an achievement we learn to be a record.

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We regret that the obituary of Mr. F. A. Ross is inevitably held over.

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PRIZE LIST, 1935.

Hichens Prize		No candidates.
Kirkes Scholarship and Gold Medal (Medal not awarded)		D. B. Fraser, P. W. Morse — Equal.
Junior Scholarships (Anatomy and Physiology)		1. R. S. Murley. 2. J. H. Gould.
Senior Scholarship (Anatomy, Physiology and Biochemistry)		L. A. Ives.
Harvey Prize		R. J. H. McMahon.
	Honourably mentioned	C. G. Fagg.
Foster Prize		D. V. Morse.
	Certificates	A. W. Little. R. J. H. McMahon. A. D. Messent.
Treasurer's Prize		G. A. Beck.
	Certificates	F. J. V. Gillingham. C. A. Jackson.
Wix Prize		H. L. M. Roualle.
Bentley Prize		A. H. Masina.
Brackenbury Scholarship in Medicine		J. W. A. Turner.
	Prox. Access.	A. R. Kelsall.
Burrows Prize		A. R. Kelsall.
Skynner Prize		L. D. B. Frost, A. R. Kelsall — Equal.
	Prox. Access.	D. Levine. J. W. A. Turner.
Brackenbury Scholarship in Surgery		G. Blackburn.
Willett Medal		G. W. Hayward.
	Prox. Access.	F. Braithwaite. C. J. Gordon.
Walsham Prize		G. Blackburn.
	Prox. Access.	G. W. Hayward.
Matthews Duncan Medal and Prize (Medal not awarded)		F. Braithwaite, I. H. Premdas — Equal.
	Prox. Access.	T. L. S. Baynes.
Entrance Scholarship in Science		H. M. Jamison.
Entrance Scholarship in Arts and Jeaffreson Exhibition	*Scholarship*	A. C. J. Saudek.
	Exhibition	I. P. M. MacDougall.
Shuter Scholarship		P. L. Candler.

OBITUARY.

ARCHIBALD EVERSDON SHARPE.

IT came as a shock to many to hear of the death of A. E. Sharpe on May 30th. It appears that while swimming that evening he suddenly collapsed and died a few hours later. The evidence at the inquest showed no trace of previous heart trouble or any other disease, and no explanation for his death was forthcoming.

Born in Calcutta twenty years ago he came of missionary parents, and was himself intending to follow in their footsteps as soon as he was qualified. He was educated at St. Michael's, Limpsfield, and later at St. Lawrence College, Ramsgate. He had just passed his second M.B. and was settling down well in his clinical work.

In sport "Archie" Sharpe was prominent: a member of the 1st XI hockey team, he will long be remembered as a skilful and robust player, a pleasant companion and a man with definite talent for leadership.

In conclusion we would express our sympathy to his relations and friends, particularly his mother and father, who are working in connection with the Purulia Leper Home, Bihar, India.

HEADACHE.

HEADACHE is a common symptom of many disorders of the body. These disorders are of most varied kinds, and include both organic and functional diseases. The clinical features of a headache may indicate its nature. One of the most characteristic headaches is that of migraine. It is recognized by its onset in childhood and adolescence and its tendency to disappear in old age. Some patients feel particularly well before an attack, and may realize this as the calm before the storm. They are well between the attacks. The attack often starts in the morning. It may be preceded by a visual aura, and generally culminates in vomiting. It is characteristically unilateral, and a past history or family history of other allergic disease supports the diagnosis of migraine. The duration of attacks varies from an hour or less to a day or more. The character of the pain and the nature of associated symptoms may vary in different attacks in the same patient. In one attack there may be a deep boring pain over the temple, and in another attack it may be a neuralgic pain like toothache, which radiates over the temporal region towards the occiput. In one attack there may be visual disturbance, fortification figures, and in another a sensation of numbness of the fingers, hands, the lips and tongue on the same side as the headache. Another characteristic headache, which is also paroxysmal, is the pain of sinusitis. In the case of inflammation of a frontal sinus, for instance, the pain is characteristically in the region of the sinus affected. It tends to come on at a certain time of the day; it is aggravated by movement, and made worse by hanging the head down. In another case it may appear in the form of neuritis of the supra-orbital nerve, with characteristic tenderness of the nerve, and radiation of the pain over the forehead towards the vertex. Hypertensive headaches may appear in much the same clinical form, localized to one side of the head, paroxysmal, and on occasion culminating in vomiting, so that the differential diagnosis between migraine, sinusitis and hypertensive attacks may be confused rather than elucidated by the clinical features of the headache. Thus a man may suffer from migraine all his life, and at the age of fifty his migraine may become worse, due to development of malignant hypertension (chronic interstitial nephritis). In such a case close cross-examination may reveal no change in the clinical features of the headache, but the reason for their increased severity is found on examination of the cardio-vasculo-renal system. Again, two patients who are both suffering from high blood-pressure and frontal sinusitis may have almost similar attacks of paroxysmal headache; the one may be so relieved of his headaches by operation on the infected sinus as to leave no doubt that the sinusitis was the cause of the attacks, while the other, although also having an infected sinus, is unrelieved by its surgical treatment. In short, while the clinical features of a headache may be so characteristic as to justify a diagnosis of their nature and cause, it may also happen that a variety of causes may be responsible for the same kind of headache. To understand these difficulties of clinical practice one needs to know the proximate causes of pains in the head.

Extra-cranial causes of headache require first consideration. Among these are included neuritis of the nerves of the scalp, such as the supra-orbital and supra-trochlear, fibrositis, perhaps associated with arthritis of the cervical spine, rheumatic myositis of the occipito-frontalis muscle, cellulitis of the scalp, and periostitis of the skull. Other local causes are inflammation of the sinuses already referred to, inflammation of the mandible or maxilla generally connected with dental sepsis, and the various headaches due to disease of the eye, such as iritis, glaucoma and including eye-strain. Another group of extra-cranial headaches depends on the fact that the trigeminal nerve is the somatic sensory nerve corresponding to the vagus. In consequence of this, as was shown by Sir Henry Head, the pain from any viscus innervated by the vagus may be within the area of distribution of the trigeminal and first two cervical nerves. Head showed that the viscera supplied by the vagus, such as the heart, lungs, œsophagus, stomach and part of the intestines, have special areas of superficial tenderness on the scalp in the temporal, vertical and occipital regions. To find localized tenderness of the scalp is therefore not sufficient to establish a local cause for the symptom. Disorder of function of a distant organ may be responsible for the tenderness. In fact to diagnose the cause of a pain in the head of extra-cranial origin the most complete examination is required, bearing in mind both the varied possibilities of the pain being of local causation, and the less frequent event of the headache being a referred pain due to disease at a distance.

Intra-cranial disease in any form is commonly accompanied by headache at some time in its course. The headaches of intra-cranial disease are paroxysmal, or if they are persistent there are paroxysmal exacerbations. A number of factors contribute to the causation of headaches of intra-cranial origin.

A rise or fall of cerebro-spinal fluid pressure, especially if it occurs suddenly, is a well-known cause of headache, which is often of the severest kind—a splitting headache in fact. A common example of this is the headache

which may follow lumbar puncture. It is more likely to follow lumbar puncture in a patient who suffers from neurasthenia or disseminated sclerosis, and rarely happens in a case of meningitis. This headache is often associated with vertigo, and sometimes with nausea and vomiting. It is increased by raising the head, and relieved by keeping the head low and by raising the foot of the bed. To prevent it plenty of fluid should be given before the lumbar puncture is performed, and when thought likely to develop, aspirin, gr. 10, with phenacetin, gr. 5, may be given before the puncture is done. The headache may be due to the leakage of cerebro-spinal fluid through the puncture wound in the theca, hence the advisability of using a small needle and withdrawing a minimal quantity of fluid. After the puncture the patient's head should be kept low on one pillow at most, extra fluid should be given, and to relieve nausea, atropine sulphate, $\frac{1}{100}$ gr., may be given subcutaneously. It may be that some cases of paroxysmal headache are due to low cerebro-spinal fluid pressure. Ephedrine hydrochloride, $\frac{1}{2}$ gr., given by mouth has been advised for the treatment of these patients. A normal cerebro-spinal fluid pressure with the patient horizontal is 60 to 150 mm. of cerebro-spinal fluid. It is rather greater in the ventricles than in the subarachnoid space, and is always lower than that of the intra-cranial capillaries. A raised cerebro-spinal fluid pressure is an important cause of headache. In congenital hydrocephalus there is little headache, because the hydrocephalus is slowly progressive, and the expansibility of the skull and its enlargement in all directions prevents any considerable increase in intra-cranial pressure. In acquired hydrocephalus, on the other hand, headache is a conspicuous symptom, and other signs of increased intra-cranial pressure, such as vomiting, head retraction, giddiness and papillœdema, are to be looked for. The headache is paroxysmal and later becomes constant, and during exacerbations the pain radiates down the neck. Whether the cerebro-spinal fluid pressure is increased or not depends on whether the hydrocephalus is communicating or obstructive in type.

In the case of a man, æt. 53, who was under observation in this hospital three years ago, there was a history of paroxysmal headache simulating migraine. At its worst the headache came on at 3 a.m., gradually increased until 8 a.m., associated with nausea and occasionally with vomiting, which gave relief. There was giddiness in severe attacks. Clinical examination was negative. The patient was admitted to hospital, and while under observation the attacks increased in severity. They were accompanied by bradycardia, and the heart-rate slowed down to 48 beats per minute. In the attacks the blood-pressure rose a little, as from 140/84 to 160/90. At this time the differential diagnosis was in terms of cerebral tumour, vaso-vagal attacks, and empyema of the sphenoidal cells. The diagnosis of cerebral tumour with intermittent hydrocephalus was finally determined by the rapid appearance of papill-lœdema to the extent of $2\frac{1}{2}$ dioptres within a period of four or five days. The diagnosis of a ball-valve tumour blocking the passage from the third to the fourth ventricle was made by Dr. Hinds Howell, and a sub-temporal decompression operation was performed by Mr. Paterson Ross. Complete relief followed this operation. There was a recurrence of symptoms a year later, but in the past eighteen months the patient has remained well. The interesting feature of this case was the fact that with recurrence of headaches there was bulging of the trephined area, the skin over which became very taut, showing the relation of the headache to increased intra-ventricular pressure.

Treatment of headache due to increased cerebro-spinal fluid pressure is by rest in bed, because the pain is influenced by posture; aspirin and phenacetin may give relief, and in severe cases omnopon, $\frac{1}{3}$ gr., or omnopon combined with scopolamine, $\frac{1}{100}$ gr., is the best combination to relieve the pain. To reduce intra-cranial pressure a rectal injection of 8 oz. 25% solution magnesium sulphate, warmed to body temperature and retained for half an hour is given, or 70 c.c. of 15% solution sodium chloride in distilled water is given by slow intravenous injection, namely, at the rate of 3 c.c. per minute. Magnesium sulphate, $\frac{1}{2}$–1 drm., may be given by mouth three times in twenty-four hours. The fluid intake is reduced to a minimum.

Another established cause of headache is a disturbance of the cerebral circulation. Venous congestion such as results from heart failure, emphysema, mediastinal tumour or thrombosis of an intra-cranial venous sinus may be a cause of severe headache. These headaches are often paroxysmal. They are aggravated by straining and by coughing, and those of extra-cranial origin are associated with cyanosis. The blood-vessels of the pia-arachnoid are under the nervous control of sympathetic and para-sympathetic fibres. It has been shown, for instance, experimentally in cats that stimulation of the cervical sympathetic in the neck by a faradic current is followed by contraction of the arteries in the pia, and stimulation of the vagus in the neck is followed by dilatation of these vessels. The local application of adrenalin to the pial vessels is accompanied by contraction of the arteries without change in blood-pressure; also intravenous injection of adrenalin causes a rise of blood-pressure with dilatation of the pial vessels, and as the blood-pressure begins to fall there is

contraction of the pial arteries. Recently nerve-endings have been demonstrated in all the vessels of the pia arachnoid and choroid plexus. There is evidence that the innervation is both sympathetic and para-sympathetic. Common examples of circulatory headaches are those provoked by arterial hyperæmia, such as may be produced by amyl nitrite and alcohol. The pain is a sense of fullness; as it increases there is a sensation of throbbing, and a severe headache is bursting and aching in character. It is associated with a flushed face, and sometimes with giddiness and epistaxis. The situation is often frontal, supra-orbital or general. Various explanations have been offered of the occipital headaches so characteristic of hypertensive arterial disease. These headaches are also paroxysmal, and though typically occipital, they may be anywhere—frontal, temporal, vertical or general. The subject has recently been discussed at length by Dr. Douglas McAlpine, who makes a distinction between one group in which there is an accompanying rise of cerebro-spinal fluid pressure, and another group in which the cerebro-spinal fluid pressure remains normal. The disorder of circulation is envisaged in terms of disturbance of the normal balance existing between the sympathetic and para-sympathetic control of cerebral circulation. Based on animal experiments and supported by post-mortem observation, it is believed that a hypertensive cerebral attack is on occasion precipitated by a further rise of blood-pressure, and the headache is due to a failure of the cerebral circulation to adjust itself to the new conditions. The local lesion may be a spasm of one or more of the cerebral arteries, and it has been shown in animal experiments that when an artery becomes extremely contracted a dilatation of its capillaries follows, with slowing of the blood-stream and extravasation of red blood-corpuscles through the capillary walls. When this extravasation is considerable, necrosis of the parenchyma may follow and lead to further hæmorrhage. The examination of the brain in the region of such a focus reveals not only sclerosis of arteries and areterioles, but also fatty changes in the walls of the capillaries, and scattered pin-point hæmorrhages in their neighbourhood, such as are also found in human post-mortem material. The treatment to be applied in such cases is venesection with the object of reducing blood-pressure. It is interesting to note that venesection may relieve the headache in such cases, even though there is no measurable change in blood-pressure. The inhalation of amyl nitrite followed by erythrol tetranitrate by mouth is also advised. Luminal is given prophylactically. When the rise of blood-pressure is accompanied by an increase in cerebro-spinal fluid pressure there may be papillœdema and retinitis, and the increase of cerebro-spinal fluid pressure is measured by lumbar puncture. In this type of case the withdrawal of cerebro-spinal fluid is advised. This requires caution. 10 c.c. are withdrawn, and if there is any increase in headache or other indication of ill-effect, the needle is withdrawn. In other cases 20 c.c. may be withdrawn, and a further 20 c.c. later. In patients suffering from persistent hypertension, who complain of a feeling of cerebral congestion or headache, and in whom there is reason to fear an attack of cerebral thrombosis or hæmorrhage, the complaint of headache is important, because it is known that cerebral accidents are often preceded for some days or even weeks by these symptoms. Headache, therefore, may be an indication for venesection and other measures to reduce blood-pressure in such patients.

Changes in the chemical constitution of the blood have also been shown to affect the pial vessels. Thus intravenous injections of hypertonic saline, the intravenous injection of pituitrin, an increase of oxygen in the blood, or a decrease of its carbon dioxide content, cause contraction of pial vessels. An increase of carbon dioxide in the blood, anoxæmia and inhalation of amyl nitrite cause a dilatation of pial vessels. It may be that on these lines, at least in part, an explanation is to be found for the great variety of headaches which are undoubtedly of toxic origin. Thus headache is a prominent symptom in smallpox, influenza, pneumonia, typhoid fever, and *Br. abortus* fever. It may be intense in the cerebral form of malaria. A chemical toxæmia may be in part the cause of the headache accompanying some forms of gastric and intestinal dyspepsia, hepatic insufficiency and constipation. In some or all of these other factors may be concerned, such as an alteration in cerebral circulation determined by a sudden fall of blood-pressure, or, as sometimes in uræmia, by a rise of blood-pressure, or again as in constipation by a reference of pain from a vagal area to the trigeminal nerve.

The brain itself and the pia arachnoid are insensitive to pain, and the headache due to variations in intracranial pressure is probably due to irritation of the endings of the trigeminal nerve in the dura mater as a result of stretching and pressure. According to the late Dr. Collier, headache does not occur on the side of the head after destruction of the fifth nerve by removal of the Gasserian ganglion. The headache produced by a sudden fall of cerebro-spinal fluid pressure, as after lumbar puncture, may thus be due to the dura mater being stretched by displacement due to the loss of cerebro-spinal fluid. Another example of ***headache due to a stretching of the dura mater*** occurs in all cases of increased intracranial pressure. It explains in part at least

the headache due to a cerebral tumour, and especially may be the cause of headache due to pituitary tumours or pituitary congestion. Thus Dr. Thompson has suggested that the attacks of migraine which occur on the first day of menstruation in women, often associated with nausea and retching, are due to swelling of the anterior lobe of the pituitary gland. He envisages a stretching of the prolongation of the dura mater which partly roofs the sella turcica between the anterior clinoid processes. On this theory he has treated patients suffering from these headaches with the intramuscular injection of theelin (50 rat units) given three times in the week before menstruation commences, and with success. Involvement of the dura mater following injury of the skull, which has led to an unresolved contusion of the brain, may be the cause of an intense and bursting headache. This headache is relieved by rest. It is absent on waking in the morning, and comes on with activity as when the patient puts on his clothes. It has been shown at operation to be associated with œdema of the meninges, and may sometimes be relieved by surgical treatment.

It is common experience that apart from disorders of cerebral circulation, organic intracranial disease is not often the cause of headaches seen in general practice. At the same time it is most important that it should always be kept in the forefront of one's mind, and detailed examination of the central nervous system must always be made in every case of headache about the nature of which there is any possible doubt. This examination needs to be repeated from time to time, because headache may be the only symptom of cerebral tumour for several years, and yet within a period of a week obvious signs of this disease may develop, and, as in the case previously quoted, papillœdema, for instance, may appear within the course of a few days.

The more usual experience of the headaches seen in general practice is to find more than one contributory cause. There are persons who never have headaches, as there are others who may develop them for most trivial reasons. Perhaps the commonest causes of headaches are a constitutional predisposition, an underlying cause, such as fatigue, and a determining factor, such as eyestrain, sinusitis or dyspepsia. In conclusion I would draw attention to the importance of *fatigue*. Eyestrain is a simple example of it. Those who suffer from bilateral deafness, perhaps because of the strained attention they must give to conversation, seem liable to a most severe and persistent form of headache when a constitutional predisposition makes them liable to this complaint. Headache, too, is common in those who live habitually just beyond their strength, particularly in brain-workers, and states of long-continued emotional strain, even when the strain is one to which the patient is so much accustomed that he is hardly aware of it. For all these people a lightening of their burdens, or an added period of complete rest horizontal for a short time every day, or for a longer time every week or month, is the best treatment to advise.

GEOFFREY EVANS.

DIVERTICULA OF THE COLON.*

"Some love Diverticulæs and turn aside into crooked ways."

INTRODUCTION.

THE presence of diverticula in the alimentary tract has always aroused the interest of pathologists, but for a long time they were regarded merely as strange curiosities. With more advanced methods of diagnosis, however, they have been found to occur much more commonly than was supposed. Moreover, the less rare varieties were attended by symptoms that required sometimes immediate, but always most careful treatment.

The earliest observers noticed that the diverticula seemed part of a general disease or predisposition, often occurring in more than one organ and in situations far apart. The fact has been continually ignored in spite of its reiteration by the leaders of the profession. As Rutherford Morison (1) has said in connection with diverticulosis of the colon, as long as attention is focused only on the special diseases of an individual organ rather than of the whole body, real advance is impossible.

Diverticula have been recorded in all of the hollow viscera and, as knowledge advances, it is becoming clear that they all owe their origin to similar factors, if not in the majority of instances to some general disorder of function. They usually arise as the result of a primary defect in the organ, or from the action of forces secondary to disease in neighbouring structures. The classification has been made of "pulsion" diverticula as the primary type and "traction" as the secondary. This is not altogether satisfactory, as it does not include a large number of cases, and also because it implies an ætiology which is by no means certain. The old pathologists devoted their attention to determining whether the pouches were "false", without the normal coats of the bowel, or "true" in character. This distinction was intended to show their origin, acquired in the first case, or congenital in the second. This has been proved, however, to be indefinite, as many diverticula accepted as acquired have been shown to

* An abstract of the Bentley Prize Essay, 1934, on "Diverticula of the Alimentary Tract".

contain in their walls all the elements of the normal tract.

It is the primary or so-called "pulsion" group that is of the greatest interest. They are, in the great majority of cases, diverticula formed by the herniation of the mucous membrane through a deficiency in the muscle-wall, or, as an American has characteristically called them, "blow-outs of the inner tube". Both factors in their causation can usually be demonstrated, an increased internal pressure, due to some disorder of contraction in most instances, but occasionally to the presence of organic obstruction, and a *locus minoris resistentiæ* as determining the site of the relief of that pressure. The diverticula occur in positions of unusual stress and generally in close relation to a sphincter. Differences in development and nervous function can often be shown in the parts, and the opinion is growing that a neurological disorder is to be blamed for the condition and it is possible that there is a congenital factor in all types.

The report was first intended to include cases only of colonic diverticulosis, as there has been an unusually large and instructive number in the Hospital wards during the year 1933–4. The reading of the literature, however, together with the discovery of a series of cases that include all the commoner diverticula and some of the very rare types, emphasized the importance of considering the condition as a whole.

Twenty-five cases were collected of patients who had been admitted during the year. The distribution was as follows:

Pharynx	2 cases.
Œsophagus	2 „
Stomach	1 case.
Duodenum—primary	3 cases.
secondary to ulceration	1 case.
Cæcum	1 „
Colon	16 cases.

DIVERTICULA OF THE COLON.

The treatment of conditions arising from acquired diverticula of the large bowel calls for the highest art of both physician and surgeon. So varied are the symptoms and so vague the signs associated with these that only the most careful investigation will bring the true cause to light. The possibility of their presence must be borne in mind by everyone whose work is connected with any of the abdominal viscera. Thus it is found that, besides the general physicians and surgeons, a share in the abundant literature of the subject has been contributed by radiologists, gynæcologists, proctologists and urologists.

The possession by a colon of diverticula does not of itself exact toll of the owner's health, but if the smallest diverticulum becomes inflamed, he stands in danger of running through the whole gamut of health and disease. From the normal health of a man who has passed middle life, with perhaps the mild and vague disorders of that age, there is a swift transition to one in whom "the form and figure of manhood has departed, the demeanour is no longer erect, and the dejected behaviour of the visage betrays the latent disquietude within. Each day is a task of painful and sickening discipline, existence being a burden" (2). Death may occur within a few hours, or the sufferings may be prolonged over a long span of years.

The condition was first mentioned in the literature in 1849 by von Rokitanski (3) and by Cruveilhier (4). For accuracy the latter's description could not be surpassed to-day, and it illustrates the small progress that has been made since. The position and structure of the diverticula must be blamed for their obscurity. They are the smallest of any in the alimentary tract, they occur chiefly in that little explored organ, the sigmoid colon, and they tend to be hidden by the appendices epiploicæ, and, if the seat of chronic inflammation, by a dense mass of fibrous tissue.

The first reference in the English literature is a report in the Pathological Society's *Transactions* of a case by Bristowe in 1854. This was followed in 1856 by a very clear account of the structures and of the disease diverticulitis by Habershon in his text-book (5). In a paper on herniæ in 1885 (6) Arbuthnot Lane mentions and illustrates a specimen which, with his comments, might well be the text for the whole subject of diverticula of the hollow viscera. In describing bladder sacculi he gives an account of an associated inguinal hernia, in which the extruded large bowel contained a number of diverticula in two rows, above a constriction of the lumen. There were also in the œsophagus two diverticula, but the description does not indicate more than that they were probably of congenital origin. Here, then, is described the association of three types of hernia in different organs, the presence of increased pressure and the distribution of the colon diverticula.

For a time all research in the subject was confined to the Continent with Gräser, Klebs, Hansemann and others. In this country there were a few "buried" case-reports, but it was not until 1903 that the first operation was performed by Rutherford Morison on a case already diagnosed as diverticulitis. This case was not reported, and the first published record is that of Moynihan in 1906 (7), who drew attention to an important feature of the disease, the "mimicry of cancer". At his suggestion, in 1908, Maxwell Telling prepared an exhaustive review of all the cases recorded at that time.

This stimulated widespread interest in the condition and, in 1917, Telling was able with Gruner to collect all the new material into the most comprehensive survey of the subject that has yet been written (8). At the same time Drummond advanced theories on the ætiology of diverticulosis, and the part played by blood-vessels in their production.

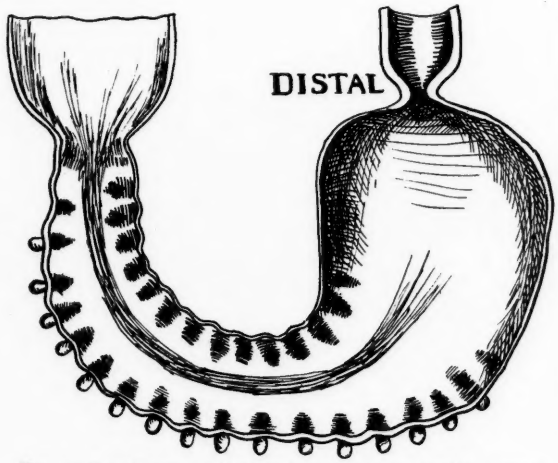

FIG. 1.—Lane's case. Diverticulous colon in an inguinal hernia.

FIG. 2.—Part of the colon from Case 13, "silent diverticulosis" discovered post-mortem. The fat has been dissected away.
A. Mesenteric tænia. B. Lateral tænia.

The first case diagnosed by radiography was reported by Abbé in 1914, but it was not until 1918 that the technique was good enough to establish the method.

The history of a disease is often to be traced in the names which are attached to it. From the old vague "sigmoiditis" of the earlier days there came "Gräser's disease", applied to the tumefaction described by him, and "Telling's disease" as a general term. "Diverticulosis" marked the first radiological observations, and "the pre-diverticular state" the more careful examination coincident with improved technique. Besides those names already mentioned as advancing the knowledge of the condition occur those of Gordon-Watson, Keith, Mummery, Spriggs, Grey Turner, Hutchison and Rolleston here, with the Mayos, Fitz and Case in America.

There has been some controversy in the naming of these protrusions. The Newcastle school, with Morison, Grey Turner and Drummond, has tried to substitute the term "sacculi"—a word for a long time used in connection with the bladder, and confine "diverticula" to those of congenital origin, such as Meckel's diverticulum. The latter term, however, is firmly established and has the support of its classical meaning—a wayside shelter or inn of bad reputation, "where sophistry and deceit are wont to tread". D. W. MOYNAGH.

(To be continued.)

ON STETHOSCOPES.

MY friend Pobjoy has bought a stethoscope. A paltry act, you suggest? A common or garden, everyday occurrence hardly worthy of note? And so it is. Stethoscopes are probably being passed across the counters of the world at every minute of the day. But the fact that this one has come into the possession of my friend Pobjoy is of some significance, worthy, I think, not only of note, but also of consideration. For Pobjoy is as yet struggling with biology and, knowing both Pobjoy and examiners as I do, I expect him to be struggling for many months yet. And the significance is this: on Tuesday last he was confronted with his first dogfish, and in the exhilarating moment of first applying a scalpel to its ventral surface he felt, he tells me, that at last he was worthy of the name of Medical Student—a humble member of the great medical fraternity. So what should the simple-minded fellow do but buy himself a stethoscope on his way home?

For in this decadent age, in which the Classics no longer hold their rightful place in the educational system, the staff of Æsculapius has given way to the stethoscope as the insignia, the badge of office of the medical profession. No doctor is worth his salt in the esteem of the lay public who does not produce a stethoscope at any and every opportunity, whether he uses it or not. The difficulty experienced by so many novices in hearing any breath-sounds in a chest is due in many cases, I am convinced, to the patient holding his breath with excitement at having this magical instrument applied to his unworthy body.

But what, it may well be asked, is this sacred thing, this juju, this talisman, this stethoscope? To get down to brass tacks (though why brass tacks should be more

suitable than anything else to get down to I have never been able to fathom; personally, I rarely, if ever, get down to a brass tack), to come, that is, to the nub (whatever that may be; I suspect it of being a close relation to the welkin), to state, as I say, the facts, a stethoscope is little more than a pair of tubes, joined at one end—a little elaborated perhaps, chromium-plated here and there maybe, but still, in essence, a pair of tubes. In fact, if one considers the matter closely, a piece of lead piping, neatly whittled down at one end to fit the ear, would do just as well, while leaving the other ear free for other things, such as listening to the radio or using the telephone. Besides which, such an instrument would be an excellent means of inducing general anæsthesia; but there are, I admit, disadvantages in this plan. It would be galling, for instance, to be taken for the plumber on visiting a strange house. Nor could a length of lead piping produced, as if by accident, in mixed company, be guaranteed to enhance the prestige of the medical student to the extent that a stethoscope does in similar circumstances. But in spite of its traditional associations, I still maintain that the stethoscope as it is to-day is an expensive gadget, unworthy of the esteem in which it is held.

The instrument has, of course, other uses than merely that of listening to chests. The chest-piece, deftly swung, may, it is true, be used to elicit the knee-jerk, though most experienced clinicians prefer, for this purpose, the edge of a hospital pharmacopœia. As a toy it will give hours of pleasure to an intelligent child, who can listen to such things as his father's watch, before and after dropping on the floor, gaining thereby a practical demonstration of the force of gravity. It can then, if applied in the right way to the right place, be used by the father to give the child a further convincing demonstration of the force of his arm. Again, it is invaluable when applied to one's wall for finding out what one's neighbours are quarrelling about. But, taken all in all and by and large, the stethoscope is not good enough value for the money.

This age, Mr. Wells tells us, is that of the conquest of power. Yet what, may I ask, has this age done for the stethoscope? Does it amplify such sounds as we wish to hear? Does it record them on steel tape for future reference? It does not. Power, however decisively Mr. Wells and his contemporaries may have conquered it, has not yet been harnessed to the stethoscope. If my challenge is taken up by the stethoscope-making profession in the right spirit, a superheterodyne, screened-grid, all-mains, Blattnerphone stethoscope should be on the market and exercising great popular appeal before the year is out. But one can have little faith in the commercial astuteness of stethoscope-makers when one considers the opportunities which have been missed already. For instance, while more than one type of stethoscope has been designed, all have been designed with but one function in view, to wit, listening. The makers of ophthalmoscopes now issue sets of spare parts rivalling in number and variety those of a vacuum-cleaner, making it possible to use the same instrument for inspecting most, if not all, of the nooks and crannies of the body. Yet where is the stethoscope with which one can also obtain a close-up view of the epiglottis, or elicit the inside story of the state of the inner ear? Not to be purchased. No one has even considered the possibilities of introducing a simple yet useful accessory, such as a pencil-sharpener or cigar-cutter, into the structure of the instrument.

Stethoscope-makers of the world, where is your initiative, where the fine fighting spirit which once forced the medical profession to abandon the cheap and simple single for the cumbersome and expensive binaural model? Take up once more the cudgels, enter once more the lists; a great future awaits you! And, when you have attained success, then and then only will we of the medical profession feel justified in recognizing the stethoscope as a symbol for all the ideals for which we stand.

D. I. CROWTHER.

CLINICAL METHODS.

The period of convalescence from acute dyspepsia and colitis, and in many cases when a low-residue diet is prescribed, is often long, and patients soon tire of a restricted menu.

These recipes and suggestions are intended to provide some variation in the "milk pudding, custard, junket" *régime* of the ordinary printed diet sheet, and include some savoury dishes for those who are not fond of sweets. Most of them are suitable for inclusion in the family menu, thus avoiding the need for cooking separate dishes for the patient.

QUEEN'S PUDDING.

2 oz. white bread-crumbs.
1 oz. castor sugar.
½ pint milk.
1 oz. butter or margarine.
1 or 2 eggs.
1 or 2 tablespoonfuls honey, jelly or strained jam (no skin or seeds).
Vanilla essence to flavour if desired.

Heat the milk and butter and pour over the bread-crumbs and most of the sugar. Allow to stand for 10 min., then add the beaten yolks of egg and vanilla, pour into a greased pie-dish and bake in a moderate oven till set (20–30 min.). Spread the honey, jelly or strained jam over the top, whip whites stiffly, folding in remainder of sugar, pile on top and bake in a slow oven till a pale golden brown.

SEMOLINA SPONGE.

1½ oz. semolina. 1 pint milk.
1 egg. Sugar to sweeten.

Heat the milk in a saucepan and sprinkle in the semolina; stir till boiling, and allow to simmer gently for about 10 min. Cool slightly, add the yolk of egg and sugar and mix well. Beat up the white of egg stiffly and fold in lightly. Pour into a greased pie-dish and bake in a moderate oven for about 20 min.

BREAD AND BUTTER PUDDING.

2 thin slices of white crustless bread (about 2 oz.).
½ pint milk. 1 egg.
Sugar to sweeten. Vanilla to flavour.
(No currants or dried fruits.)

Spread the bread with butter, cut into small pieces and arrange in a greased pie-dish. Beat the egg slightly, add the milk, sugar and flavouring. Strain over the bread and allow to soak for 20 min. Bake in a moderate oven till set.

CHOCOLATE MERINGUE PUDDING.

1 pint milk. 1 or 2 eggs.
1½ oz. cornflour. ½ oz. cocoa.
1 oz. sugar. Vanilla to flavour.

Make the chocolate blancmange in the usual way, add most of the sugar and, when slightly cool, the beaten yolk of egg. Pour into a greased pie-dish. Whip the whites up stiffly with the remainder of the sugar, pile on top and bake in a slow oven until golden brown.

STEAMED CHOCOLATE PUDDING.

4 oz. margarine. 5 oz. flour.
4 oz. sugar. 1 teaspoonful baking powder.
2 eggs.
A little milk. 1 oz. cocoa.

Cream the fat and sugar; add each egg separately with a little flour and beat well. Add the rest of the flour, cocoa and baking-powder. A little milk may be added if necessary, so that the mixture is of a dropping consistency. Turn into a greased basin, cover with greased paper and steam till well risen and firm. Serve with chocolate sauce.

CHOCOLATE SAUCE.

½ pint milk. Sugar to sweeten.
½ oz. cornflour. 1 teaspoonful cocoa.

Blend the cornflour and cocoa with a little cold milk. Bring the remainder of the milk to the boil; add the cornflour, stirring well. Cook 3 min., sweeten with sugar and serve.

Note.—A similar pudding may be made with strained orange-juice to flavour instead of cocoa and served with an orange sauce, or made with vanilla flavouring and served with custard sauce.

HONEYCOMB MOULD.

1 pint milk. ½ oz. powdered gelatine.
2 or 3 eggs. Strained orange juice, lemon essence or vanilla to flavour.
2 oz. sugar.

Make a boiled custard with the milk, yolks of eggs and sugar; add flavouring and allow to cool. Dissolve the gelatine in about two tablespoonfuls of water; add to the custard. Beat the whites of eggs stiffly and fold in. Pour into wet moulds and when set turn out.

EGG JELLY.

1 pint water. Sugar to sweeten.
½ oz. gelatine. Vanilla to flavour.
2 or 3 eggs.

Dissolve the gelatine in the water. Beat up the eggs; add to the gelatine and water, which should be hot enough to cook the egg, but not to curdle the mixture. Strain, add the vanilla and sugar, and pour into wet moulds. When set turn out.

STEAMED CARAMEL PUDDING.

2½ oz. white bread. 2 oz. sugar.
½ pint milk. 2 or 3 eggs.

Place the sugar with 2 tablespoonfuls water in a saucepan, stir till dissolved, boil till a golden-brown colour, and quickly add the warmed milk. Stand aside to cool. Add the beaten eggs. Cut the bread into small cubes and strain the custard over the bread; allow to soak. Turn into a greased mould and steam gently until set. Serve hot or cold.

TOMATO AND SPAGHETTI.

½ pint tomato purée (fresh or tinned).
½ pint water or vegetable stock.
½ oz. flour. 2 oz. spaghetti.
½ oz. margarine. Salt to season.

Melt the fat, add the flour, water, tomato purée and salt. Stir well till boiling. Cook 2 or 3 min. Boil the spaghetti in water till soft. Strain, add to the sauce and serve.

This may be served with scrambled egg if liked.

FISH OR CHICKEN SOUFFLE.

4 oz. cooked, flaked white fish, haddock or pounded chicken.
1 oz. margarine.
1 oz. flour.
¼ pint milk (or equal parts of milk and fish or chicken stock).
2 eggs.
Salt to season.

Melt the fat, add the flour and milk. Mix well and stir till boiling. Add the flaked fish or pounded chicken, the yolks of the eggs, and a little salt to season. Beat the egg-whites stiffly and fold in. Turn the mixture into a greased mould, cover with greased paper and steam very gently about 45 min. When firm turn out, coat with white sauce and serve.

OTHER SUITABLE DISHES.

Trifle, made with jelly or honey instead of jam, and decorated with whipped cream or chopped jelly (no cherries, angelica or nuts).

Chocolate trifle, made with plain or chocolate sponge cake and chocolate custard.

Plain jelly containing cubes of sponge cake. This may be served with custard sauce or cream if desired.

Meringue and cream.

Ground rice-mould, served with golden syrup, honey or jelly (no fruit or jam).

Caramel custard.

Chocolate junket.

Creamed rice, ground rice, sago or semolina.

Fresh milk cheese or cream cheese and plain biscuits (not digestive, wholemeal, ryevita or vitawheat).

M. S.,
Assistant Dietician.

BRIGHTER SURGERY.

III.

POLYLAPAROTOMY.

I'm going to relate
And, what's more, substantiate
Some facts concerning one of my relations.
In her the surgeons found
A happy hunting-ground—
In all, she'd had eleven operations.

She'd acquired her longest scar
When, run over by a car,
They looked about for intestinal lesions.
And, of course, she'd gathered lots
In all the usual spots;
The rest were all for multiple adhesions.

They'd taken out her spleen,
And on the fluorescent screen
Her stomach too showed signs of faulty function.
Soon *that* was taken out,
And her skin was cut about
Like a panoramic view of Clapham Junction.

Of her viscera bereft,
Yet her uterus was left,
And it wasn't long before she was a mummy.
When a female child she bore
The wretched infant wore
A zipp-fastener right down its little tummy. A. B.

COLLEGE APPEAL FUND.

SUBSCRIPTIONS TO DATE.

	£	s.	d.	*	†
Staff	13,155	5	10	(73)	
Demonstrators	1,758	2	0	(70)	
Students	1,026	17	9	(311)	
Old Bart.'s men:					
‡Bedfordshire	40	13	6	(8)	(26)
Berkshire	123	3	0	(16)	(37)
‡Buckinghamshire	82	4	0	(15)	(29)
‡Cambridgeshire	193	16	0	(18)	(42)
‡Cheshire	6	16	6	(3)	(26)
‡Cornwall	32	12	0	(9)	(36)
Cumberland	5	0	0	(1)	(6)
Derbyshire	19	14	0	(4)	(17)
‡Devonshire	574	0	0	(53)	(98)
‡Dorset	52	11	6	(14)	(30)
‡Durham	17	7	0	(4)	(11)
Essex	254	3	6	(20)	(69)
‡Gloucestershire	238	7	6	(27)	(52)
Hampshire	475	7	0	(49)	(134)
‡Herefordshire	17	12	0	(4)	(10)
Hertfordshire	86	13	0	(18)	(73)
Huntingdonshire					(1)
Isle of Wight	191	13	0	(13)	(25)
‡Kent	584	1	0	(71)	(146)
‡Lancashire	96	4	6	(13)	(82)
Leicestershire	136	15	0	(7)	(28)
‡Lincolnshire	60	8	0	(18)	(27)
‡Middlesex	463	5	0	(33)	(63)
‡Norfolk	178	0	6	(21)	(60)
‡Northamptonshire	59	14	6	(6)	(17)
‡Northumberland	101	1	0	(2)	(11)
‡Nottinghamshire	24	3	0	(5)	(28)
‡Oxfordshire	221	5	0	(22)	(26)
Rutland	1	1	0	(1)	(2)
Shropshire	38	1	0	(10)	(22)
‡Somersetshire	1,180	3	0	(28)	(43)
Staffordshire	194	18	0	(6)	(37)
‡Suffolk	324	4	0	(25)	(46)
Surrey	519	14	6	(60)	(180)
Sussex	543	12	0	(60)	(174)
‡Warwickshire	201	6	0	(21)	(64)
Westmorland	2	10	0	(1)	(5)
‡Wiltshire	1010	11	0	(12)	(26)
‡Worcestershire	160	0	6	(25)	(25)
‡Yorkshire	348	1	6	(28)	(101)
Wales	68	11	0	(19)	(150)
London	7,586	19	8	(202)	(971)
Channel Islands	20	0	0	(2)	(9)
Scotland	15	5	0	(5)	
Abroad	119	1	0	(13)	
South Africa	366	15	6	(19)	
Canada	114	3	6	(8)	
East Africa	87	12	0	(10)	
West Africa	146	10	0	(5)	
India	207	12	0	(13)	
Ireland	25	4	0	(4)	
North Africa	1	0	0	(1)	
North Borneo	10	10	0	(1)	
Australia	122	2	0	(6)	
China	52	8	4	(9)	
Siam	10	0	0	(1)	
France	50	0	0	(1)	
British West Indies	55	8	0	(6)	
Straits Settlements	7	1	0	(3)	
New Zealand	6	1	0	(3)	
Services	644	4	6	(46)	
Others	63,757	12	11	(540)	
Lord Mayor's Appeal	17,990	16	0		
Funds of College	8,000	0	0		
Value of Building	20,000	0	0		
	£144,265	**16**	**6**		

* Number of Bart.'s men subscribing. † Number of Bart.'s men in County. ‡ Counties with Secretaries.

STUDENTS' UNION.

CRICKET CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* LEAVESDEN.

May 25th. Leavesden batted first on a hard wicket, and their opening pair, batting with precision, scored 200 runs before Mundy, who never gave up the seemingly hopeless task of separating them, got Coverdale lbw for 136. Leavesden declared at 257 for 2.

Johnstone and Dransfield gave the Hospital a good start of 64 for the first wicket. The wicket now began to show signs of wear. Brown batted courageously after being hit on the head, but the rest of the side collapsed badly, Simpson being caught out off the last ball of the match by a fieldsman who had crept up closer to him than the wicket-keeper. Bart.'s lost by 124 runs.

C. M. Dransfield, c Coverdale, b Marsland	20	C. R. Morison, b Marsland	0
J. S. Johnstone, b Wells	47	R. Mundy, not out	0
D. J. A. Brown, c Lambkin, b Palmer	17	J. J. Slowe, b Marsland	0
R. C. Dolly, c and b Wells	1	J. R. Simpson, c Stephenson, b Watson	1
W. M. Maidlow, c Wells, b Palmer	4	Extras	17
C. J. Nicholson, b Wells	4		
M. H. Harmer, c Coverdale, b Watson	12	Total	123

	Overs.	Mdns.	Runs.	Wkts.
Mundy	21	5	66	2
Dolly	9	1	56	—
Simpson	3	2	54	—
Harmer	5	—	29	—
Nicholson	7	1	30	—
Morison	1	—	12	—

ST. BARTHOLOMEW'S HOSPITAL *v.* MIDDLESEX HOSPITAL.

(Cup-Tie.)

May 26th. The absence of Cochrane, Anderson and Johnstone cannot entirely explain the Hospital's very poor showing in this game. The Middlesex first pair, despite accurate bowling by Mundy and Dolly, backed up by keen fielding, scored 120 before lunch. A quick wicket after lunch and the remainder for 160 left the Hospital 281 to score to win.

Our innings began disastrously, Dransfield and Dolly being out for 9 runs. Wickets fell with uneasy frequency, and 6 were down for 43. Brown then batted confidently for 50, but with his wicket the end came, Bart.'s being all out for 119.

C. M. Dransfield, b Getken	2	R. Mundy, b Thompson	2
F. E. Wheeler, b Getken	12	W. M. Maidlow, b Muir	16
R. C. Dolly, b Getken	2	C. G. Nicholson, b Buxton	18
C. R. Morison, c Thompson, b Muir	7	J. J. Slowe, b Lenton	4
D. J. A. Brown, c Miller, b Lenton	50	J. R. Simpson, not out	4
M. H. Harmer, c Thompson, b Getken	0	Extras	2
		Total	119

	Overs.	Mdns.	Runs.	Wkts.
Mundy			66	2
Dolly			40	1
Morison			19	0
Nicholson			21	0
Simpson			30	3
Dransfield			9	0
Harmer			56	4

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. GEORGE'S.

June 1st. A delightful game, played in the true style and surroundings of country-house cricket, marked the opening of St. George's ground at Wimbledon.

The Hospital batted first, and Dolly, opening, scored 50—the best innings for the Hospital this season. Dransfield crashed the first six on the ground into an oak, and was out immediately afterwards trying to repeat the shot at the expense of a copper beech. After a rapid change from 120 for 2 to 160 for 9, Bart.'s were all out for 177.

Anderson and Mundy quickly disposed of batsmen Nos. 1 and 2 for 20 runs, but then a consolidation of the George's position took place to 140 for 2. But wickets again began to fall, and time came with St. George's with only two wickets in hand, still requiring 30 runs to draw.

PAST *v.* PRESENT.

June 8th. This very pleasant game was played at Winchmore Hill on June 8th. Both the Past and Present fielded strong elevens.

Nunn and Boney opened the Past batting to bowling which at times was difficult. Nunn batted attractively before he was out at 44. The score was then carried on, steadily by Boney, merrily by Gabb—who batted exceedingly well—and by Capper to 120. Then began a minor collapse, caused as much we think by the boastful threats of the bowlers as by their spins and swingers. Some useful batting by Dr. Bourne increased the total to 172, when the Past were all out.

For the Hospital North scored 52 in his first knock—a good innings, characterized by heavy pulling and cutting of the short ball. Morison's 39 was typically sound, but wickets fell at all too short intervals, and with the last pair in, the Hospital still needed 9 runs to win. A single, two no-balls (happy thoughts, by a Present umpire) and a post-mature four off the last ball of the day brought the score to within one of the Past, and an excellent and pleasant game to an unfortunately drawn ending.

F. E. Wheeler, lbw, b Gabb	14	R. Mundy, c sub, b Nunn	17
C. M. Dransfield, b Gabb	9	J. J. Slowe, not out	2
J. North, b Maley	52	J. R. Simpson, c Nunn, b Gabb	2
R. C. Dolly, st Hunt, b Witteridge	8	J. Craig Cochrane, not out	4
D. J. A. Brown, lbw, b Maley	13	Extras	11
C. R. Morison, c and b Gabb	39		
W. M. Maidlow, b Maley	0	Total (for 9 wkts.)	171

	Overs.	Mdns.	Runs.	Wkts.
Cochrane	23	6	54	6
Mundy	11	2	36	—
Dolly	11	2	22	2
Simpson	7	—	35	1
Morison	1	—	4	—

ST. BARTHOLOMEW'S HOSPITAL *v.* CROYDON.

June 10th. It was unfortunate that for this good fixture the Hospital side was considerably weakened by the absence of Mundy, Morison, Dransfield and Dolly, and had to play one man short.

A start was only possible after lunch, when the Hospital batted first. Our tale was a sorry one of quick wickets and low scoring, with the innings closing at 87. Barnett, in a short stay, attracted.

Croydon passed this total for the loss of only two wickets, and then proceeded to play much bright and attractive cricket to close their total at 241.

Harmer, for Bart.'s, bowled very well, turning the ball sharply, to take five wickets, one a remarkable one-handed catch by Maidlow at short mid-off.

J. S. Johnstone, c Saunders, b Harding	11	S. T. Hayes, c and b Isard	3
D. J. A. Brown, c Saunders, b Isard	12	J. D. Burnett, b May	8
M. H. Harmer, b Harding	5	J. Craig Cochrane, not out	23
W. M. Maidlow, c Lancaster, b Isard	15	J. R. Simpson, st Saunders, b Isard	3
A. W. Little, c Mason, b Harding	1	J. Darke, c Ratcliffe, b Isard	0
		Extras	6
		Total	87

ST. BARTHOLOMEW'S HOSPITAL *v.* M.C.C.

June 22nd. This match is one which the Hospital has always been keen to win. On this occasion we almost succeeded.

The M.C.C. batted first on a wicket which was taking a lot of "bite". The innings opened sensationally with two wickets down for 10 and three for 19. A stand for the fourth wicket took the score to 55, when Dolly ran into a spell of well-deserved, though occasionally fortunate, wicket-taking. At lunch eight M.C.C. wickets were down for 63, and the innings closed at 88. Mundy bowled well, and Simpson better, perhaps, than he has so far in a good season. The Hospital fielded well.

The Hospital went in with hopes of a big victory, only to find themselves, even after a good stand by Mundy and Maidlow, and another by Mundy—whose innings was commendable—and Slowe, needing four runs for the last wicket to win. Three of these came from a good leg-glance by Slowe, but with no addition to the score he was out, and a very exciting game ended in a tie.

C. M. Dransfield, b Nunn	18	J. J. Slowe, c Priestley, b Morrison	12
J. S. Johnstone, b Morrison	1	J. Craig Cochrane, b Morrison	5
R. Heyland, lbw, b Nunn	0	J. R. Simpson, not out	0
D. J. A. Brown, run out	0	Extras	9
J. North, c Morrison, b Nunn	0		
R. C. Dolly, c and b Morrison	3	Total	88
W. M. Maidlow, b Morrison	11		
R. Mundy, b Nunn	29		

	Overs.	Mdns.	Runs.	Wkts.
Mundy	8	3	23	2
Simpson	9	1	22	1
Dolly	7	2	19	4
Cochrane	6	1	12	3
Dransfield	1	—	9	—

SWIMMING CLUB.

The Swimming Club opened their season with a match against Lensbury Swimming Club at St. George's Baths, Buckingham Palace Road. Unfortunately the best team could not be turned out, so that numbers had to be made up with reserves.

The fixture began with a four-a-side team race, which turned out to be a very close event and was won by Bart.'s. Each member of the team had to swim one length of 33⅓ yards, and the last man, Singer, a new member of the Club, finished up in capital style a yard ahead of his rival.

A water polo match followed and did not provide such equal competition. Bart.'s were lucky enough to win the toss, but were well beaten, 6—0. The whole team was ragged and very slow, and did not efficiently mark the opposition.

Team swimming.—(1) P. Saltman, (2) T. O. McKane, (3) A. C. Kanaar, (4) H. G. Singer. Won by 1 yard.

Water polo.—D. G. Evans, P. Quibell, F. T. Moore, A. C. Kanaar, P. Saltman, Singer, T. O. McKane. Lost, 6—0.

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD MILLHILLIANS.

Bart.'s met Old Millhillians Swimming Club at Fitzroy Baths for swimming and water polo. This was the first full fixture, and showed how the team had progressed since the previous match.

The swimming consisted of three events: 2 lengths, 1 length, and a team race of four aside. There were two strings in the two individual events.

The 2 lengths race was won by A. C. Kanaar with Singer third. There was only a touch between the four men.

The 1 length race was almost as even, and was won by T. O. McKane with P. Saltman fourth.

The team race of four aside was very even, but the fine efforts of Singer and A. C. Kanaar just enabled the Hospital to win by a yard.

The water polo match was a great improvement on the previous one and the whole team played together much better, although a trifle slow at times. Goals were scored by A. C. Kanaar and T. O. McKane.

Swimming.—2 lengths, A. C. Kanaar (1), H. G. Singer (3). 1 length. T. O. McKane (1), P. Saltman (4).

Team race.—P. Saltman, T. O. McKane, H. G. Singer, A. C. Kanaar. Swimming: Bart.'s, 18 pts.; Old Millhillians, 9 pts.

Water polo.—L. R. Taylor, P. Quibell, T. O. McKane, A. C. Kanaar, P. Saltman, H. G. Singer, B. M. Phillips. Drawn, 2—2.

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD PAULINES.

The Hospital played their third match of the season against the Old Paulines at St. Paul's School. It was very difficult to raise a full team owing to View Day falling on the same day, so that the water polo match could not be played. The swimming proved very exciting, and all the races were won by less than a yard.

Swimming.—2 lengths, A. C. Kanaar (1), H. G. Singer (3). 1 length, T. O. McKane (2), P. Saltman (4).

Team race.—P. Saltman, T. O. McKane, H. G. Singer, A. C. Kanaar.

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. THOMAS'S HOSPITAL.

This match was the first league fixture of the season and the first match of the new system. Previously inter-hospital competitions had been carried out under the knock-out system. Under the league system every hospital will play all the others in turn, counting two points for a win and one for a draw. The trophy will be awarded to the first team in the league. If two teams finish with an equal number of points, goal average will decide the winner.

The Hospital were able to turn out one of their strongest teams, and easily won a rather uninteresting game by 9 goals to *nil*. The only interesting feature was the improved play of the Hospital team and the sureness of the passing. Goals were scored by R. J. C. Sutton (3), J. C. Newbold (2), T. O. McKane (2), P. Saltman (1), B. H. Goodrich (1).

Team.—C. M. Dransfield, P. Quibell, B. H. Goodrich, R. J. C. Sutton, P. Saltman, J. C. Newbold, T. O. McKane.

THE ST. BARTHOLOMEW'S HOSPITAL GOLFING SOCIETY.

The Eighth Summer Meeting of the Society was held at Ashridge on Thursday, June 13th. The course is situated in a magnificent park and was beautiful to play over. Unfortunately our numbers were smaller than usual for a Summer Meeting—coming so near Whitsuntide was thought to be partly responsible for this. Sixteen players took part in the Singles and Foursomes, and twelve stayed on for supper. The weather was excellent, and with the beautiful surroundings it was a perfect day.

The following are the results of the competitions:

SINGLES.

Gordon-Watson Cup.

C. A. Francis	All square.
E. E. Llewellyn, J. G. Milner	1 down.

Last Nine Holes.

W. A. Barnes	1 up.
C. A. Francis	All square.
E. E. Llewellyn, K. D. Waters	1 down.
J. G. Milner	2 „

Sealed Holes.

J. G. Milner	All square.
G. Graham, E. E. Llewellyn	1 down.
K. D. Waters	2 „

FOURSOMES.

W. A. Barnes and C. A. Francis, R. S. Corbett and K. D. Waters	2 down.

First Nine Holes.

W. A. Barnes and C. A. Francis	All square.
R. S. Corbett and K. D. Waters	1 down.
E. T. D. Fletcher and F. E. Saxby Willis	3 „

Sealed Holes.

R. S. Corbett and K. D. Waters	2 up.
W. A. Barnes and C. A. Francis, G. Graham and J. Spencer	1 down.

LAWN TENNIS CLUB.

The weather has been very unkind to lawn tennis players during the month of June, and consequently many matches have had to be scratched. Up to the time of writing the 1st VI have played 6 matches and only lost 1. The 2nd VI have played 6 matches and have lost 1. These results are definitely encouraging.

The " Past *v.* Present " match was as usual played at Winchmore Hill, and although the Past had not so formidable a team as in previous years, we spent a very enjoyable afternoon. The 1st VI are out of the Inter-Hospitals Cup Competition; owing to the weather the second round was decided by the " spin of a coin ", and unfortunately we lost, and so ended our dreams of winning the Cup.

The 2nd VI have certainly lived up to the promise they showed early in the season, and are now in the final of the Junior Cup, having beaten U.C.H. by 11 matches to *nil*, and London by 10 matches to 2.

1st VI.

v. Wentworth Club at Wentworth on Saturday, June 22nd; won 4—1. E. Corsi and W. K. Frewen beat 1st pair 6—3, 10—8; beat 2nd pair 7—5, 6—1.

B. Thorne-Thorne and J. R. Kingdon beat 3rd pair 6—3, 7—5.

R. C. Witt and J. W. B. Waring beat 3rd pair 6—2, 6—2; lost to 1st pair 3—6, 6—4, 4—6.

2nd VI.

v. University College Hospital, at Perivale; won 11—0.
v. London Hospital, at Winchmore Hill; won 10—2.
v. Northampton Engineering College 1st VI; won 7—1.

BOXING CLUB.

At the Annual General Meeting of the Boxing Club held in the Abernethian Rooms on Tuesday, June 18th, the following officers were elected for 1935–36:

President.—Mr. W. Girling Ball.
Vice-Presidents.—Mr. A. M. Boyd, Dr. Wilfred Shaw.
Captain.—J. J. Slowe.
Hon. Sec. and Treasurer.—T. P. Storey.
Committee.—C. F. Bose, J. W. Perrott, J. James.

CORRESPONDENCE.

SECONDARY ABDOMINAL GESTATION.

To the Editor, 'St. Bartholomew's Hospital Journal'.

DEAR SIR,—The case of secondary abdominal gestation described by Dr. Darmady in the June issue of the JOURNAL interested me because a colleague here, Dr. Howard English, was not long ago called to see a patient whose condition proved to be one of full-term extra-uterine pregnancy.

The woman was due to deliver her first child in August, and at that time she had a spurious labour. As there were no further developments by October, she was advised to consult her doctor, who, being able to palpate fœtal parts, yet hearing no heart-sounds, suspected from the history and from vaginal examination that the case was one of extra-uterine pregnancy, and so the woman was admitted to our local hospital.

A sound indicated that the internal length of the uterus was 3 in., and the abdomen was opened.

After a large, thick swelling, looking not unlike the uterus, had been incised, a full-term dead fœtus, and afterwards the placenta, were removed, the bleeding at this stage being agreeably slight. A general survey now suggested that the condition was one of right extra-peritoneal or broad ligament gestation; and this diagnosis was soon to be unpleasantly confirmed by the observance of a small leakage of urine; for the ureter, dragged up out of position by the ever-expanding sac, had been so stretched and flattened as to be almost indistinguishable from the sac itself, and the incision had severed it completely. This unfortunate mishap necessitated the removal of the right kidney.

The separation of dense adhesions from the sac, which completely enveloped the uterus, left that organ so denuded of peritoneum that it was deemed advisable to remove uterus, sac and adhesions *en bloc*. Then was it possible to repair the pelvic floor, although subsequent oozing could only be arrested by plugging the cavity for twenty-four hours. Recovery was uneventful.

My reason for writing is that I did not realize, until I read Dr.

Darmady's interesting article, that the condition of full-term extra-uterine pregnancy was so rare, and so it seemed worth my while to describe this case. Also, I am wondering whether the statement is correct that between 1910 and now no case of extra-uterine pregnancy where the fœtus had evidently attained a life of 3½ months has been admitted to Bart.'s. In 1924, as house surgeon of the Unit, I admitted a woman who, at laparotomy, was found to have an extra-uterine pregnancy with twins, and, if my memory is not at fault, the estimated age was 4½ months. The notes would show whether the passage of years has increased in my mind the age of the twins.

During the six months that I was Intern we had a run of cases of ectopic gestation so much so that I remember Dr. Donaldson remarking that such a surfeit (31 I think) gave the students quite an erroneous idea of its prevalence. I have only seen six cases in ten years of general practice, and of these, three occurred in practices other than my own. It is my experience that the frequency of the incidence of ectopic gestation and mastoiditis are about the same.

My thanks are due to Dr. Howard English, who so readily gave me full details and permission to quote his case.

G. S. W. EVANS.

Moorings,
Willaston, Nantwich;
June 21st, 1935.

REVIEW.

INDIVIDUAL HEALTH: A TECHNIQUE FOR THE STUDY OF INDIVIDUAL CONSTITUTION AND ITS APPLICATION TO HEALTH. By E. OBERMER. Vol. I: Biochemical Technique. By E. OBERMER and R. MILTON. (London: Chapman & Hall, Ltd., 1935.) Pp. xvi + 244. 40 figures, 4 folded charts and 22 graphs. Price 15s.

There is undoubtedly room for a combined clinical and laboratory study of normal beings, and a description of his programme and methods is the object of the two volumes entitled "Individual Health". The author has set himself a colossal task. He proposes to assess (i) the effect of heredity from the family history and anthropometric measurements, (ii) the nature of external factors from the past history and physical examination, including bone radiology and dental examination, and (iii) the subject's reaction to present external factors, "directly" by physical or mechanical means, and "indirectly" by biochemical means. In short he will supplement a very thorough clinical examination by an extremely elaborate series of laboratory tests. There is very little new in the tools he uses. Presumably the results, which are what most of his readers will want to see, will be published later. We feel that perhaps it would have been better simply to name the tools when publishing the results, thus saving the issue of two volumes. That, however, may be an unfair suggestion, for only one of the two volumes has so far been published.

This first volume deals mainly with biochemical technique. The organization of his laboratory is naturally of great interest to the author, but we doubt whether it will appeal much to his readers. The tests are very clearly set out. They are, however, in most cases well-accepted methods previously published in some instances many times over. Whenever possible the author uses a colorimetric method, and further he prefers a photometer (he calls it a "densitometer") to an ordinary colorimeter to make his final reading. We can understand this preference in making large numbers of analyses, but the apparatus is expensive, and for each instrument graphs have to be prepared for each method to convert the photometric readings into terms of the concentration of the substance being analysed. His graphs will be of the utmost value in his own laboratory, but of only limited use to those working elsewhere.

He appends a chart for recording results; if each subject was submitted to only half the tests listed, the cost would be enormous; it would be unfair to say that it is not worth while until the results are available. On this same chart the normal figures are given for many of the analyses, though several which are well known are omitted; in a few instances the stated range of variation in health is too small, and would be misleading in interpreting results.

The book will be of limited value to those engaged in biochemical analysis, and of special interest to those employing a photometer.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

ABRAHAMS, MARGERY, M.A.(Oxon.), M.S.(Columbia Univ. N.Y.). "The Organisation of a Dietary Department." *Medical Press and Circular* (Supplement), April 10th, 1935.

ADAMSON, H. G., M.D., F.R.C.P. "Eczema as a Clinical Entity, and its Fundamental or Essential Lesions." *Clinical Journal*, April, 1935.

ARCHER, H. E., M.R.C.S., L.R.C.P. *See* Klaber and Archer.

COCKAYNE, E. A., D.M., F.R.C.P. (and KRESTIN, DAVID, and SORSBY, A.). "Obesity Hypogenitalism, Mental Retardation, Polydactyly and Retinal Pigmentation: The Laurence-Moon-Biedl Syndrome." *Quarterly Journal of Medicine*, April, 1935.

D'ABREU, FRANK, F.R.C.S. "Three Unusual Cases of Renal Disease." *British Journal of Urology*, March, 1935.

FRASER, FRANCIS R., M.D., F.R.C.P. "Prognosis in Toxic Goitre." *Lancet*, April 13th, 1935.

GASK, GEORGE E., *C.M.G., D.S.O.*, F.R.C.S. "British Masters of Medicine: Percivall Pott (1714–1788)." *Medical Press and Circular*, April 3rd, 1935.

GRAHAM, GEORGE, M.D., F.R.C.P. "Diet in Colonic Disease." *Medical Press and Circular* (Supplement), April 10th, 1935.

GROVES, E. W. HEY, M.D., F.R.C.S. "Organization of the Treatment of Fractures." *British Medical Journal*, April 20th, 1935.

——— Translator and Editor of Bohler's *Treatment of Fractures*, Fourth English edition. Bristol: John Wright & Sons, 1935.

GWILLIM, C. M., M.D., F.R.C.S. (and MATHESON, L. M., M.B.(N.Z.), F.R.C.S.). "A Case of Cancer of the Uterus showing Extensive Glandular Involvement." *Journal Obstetrics and Gynæcology British Empire*, April, 1935.

KLABER, R., M.R.C.P., and ARCHER, H. E., M.R.C.S. "Iodide Eruption due to Wearing Iodine Locket." *Lancet*, March 30th, 1935.

LINDER, GEOFFREY C., M.D., M.R.C.P. "The Influence of Infection on the Action of Parathyroid Hormone in Man." *Quarterly Journal of Medicine*, April, 1935.

PAVEY-SMITH, A.B., *M.C.*, M.B., F.R.C.S. (and MILLER, S., M.R.C.P.) "Lateral Sinus Thrombosis due to *Bacillus proteus*." *Lancet*, April 13th, 1935.

TREVOR, D., F.R.C.S. "Perforated Jejunal Ulcers." *Lancet*, March 23rd, 1935.

WOODWARK, Sir STANLEY, *C.M.G., C.B.E.*, M.D., F.R.C.P. *Manual of Medicine*, 4th edition. London: Oxford University Press, 1935.

EXAMINATIONS, ETC.

University of Cambridge.

The following Degrees have been conferred:

M.D.—Abercrombie, G. F., Day, G. H.

M.B., B.Chir.—Sugden, E. C.

M.B.—Briggs, G. O. A., Gabb, W. H., Hulbert, N. G., Roper, R. D.

B.Chir.—Gabb, R. T., Warren, W.

Second Examination for Medical and Surgical Degrees, Easter Term, 1935.

Part II.—Levin, A., Neatby, G. O. M., Quibell, E. P., Sinclair-Loutit, K. W. C., Somerville, E. W.

Third Examination for Medical and Surgical Degrees, Easter Term, 1935.

Part I.—Black, K. O., Debenham, G. R., Gabb, R. T., Gordon, C. J., Haynes, W. S., Kelsall, A. R., Lesser, S. A. H., Morison, C. R., Pirie, A. H., Robinson, V. C., Scott, P. G., Stallard, A. F., Tooth, G. C., Warren, W.

Part II.—Blackburn, G., Cookson, J. S., Daniel, T. M., Debenham, G. R., Drake, E. P. H., Gabb, R. T., Gordon, C. J., Hewlings, N. J. P., Kelsall, A. R., Paterson, J. F., Patterson, J. H., Webb, J. G.

University of London.

Third (M.B., B.S.) Examination for Medical Degrees, May, 1935.

Honours.—*Hayward, G. W. (*a, b, c, d, e*).

* University Medal.

a. Distinguished in Medicine.

b. Distinguished in Pathology.

c. Distinguished in Forensic Medicine and Hygiene.

d. Distinguished in Surgery.

e. Distinguished in Obstetrics and Gynæcology.

Pass.—Atkinson, E. C., Bangay, E. B. D., Barber, D. S. D., Bohn, G. L., Dexter, L., Dipple, P. E., Harvey, P. G. F., Houghton, A. W. J., Houghton, P. W., Jones, D. M., Thomas, B. A., Thomson, D. M.

Supplementary Pass List.

Group I.—Cates, B., Higginson, H. C. H.

Group II.—Frost, L. D. B., Hill, J. R., McGladdery, H. M., Mason, J. I. C., Pentreath, E. U. H., Sheehan, D. J.

Royal College of Surgeons.

The Diploma of **Fellow** has been conferred on the following:

Agar, H., Beattie, D. A., Buttsworth, B. W., Cholmeley, J. A., Ghey, P. H. R., Hindenach, J. C. R., Howard, R. N., Lambert, C. R., McEachern, A. C., Madan, J. N., Murphy, F. D., Murray, R. W. C., Rawle, R. M., Scholes, J. L., Sen, A. K., Spencer, S. L., Swinburne, T. G., Watson, H. A. W., Wyndham, N. R.

The following were successful at the Examination for the **Primary Fellowship:**

Bateman, A. D., Capper, W. M., Chandra, S. R., Gilbert, R. G., Harmer, M. H., Ives, L. A., Lumsden, K., Messent, A. D., Morel, M. P., Morse, D. V., Treissman, H.

CHANGES OF ADDRESS.

BARNSLEY, Major R. E., R.A.M.C., Headquarters, British Troops in Egypt, Cairo, Egypt.

BEATTIE, JOHN, 20, Upper Wimpole Street, W. 1. (Tel. Welbeck 8448.)

BERRY, Sir JAMES, Crestway House, Dover House Road, Roehampton, S.W. 15. (Tel. Putney 4519.)

DAY, G. H., The Sanatorium, Mundesley, Norfolk.

DOYLE, J. L. C., Barons Hall, Fakenham, Norfolk. (Fakenham 38.)

EDWARDS, W., 133, Pollards Hill South, S.W. 16.

EYTON-JONES, F. M. M., Gatewick, 10, Granville Road, Littlehampton. (Tel. 400.)

GLOVER, L. G., 1*a*, Netherhall Gardens, Hampstead, N.W. 3. (Tel. Hampstead 1070.)

ILIFF, A. D., C.M.S. Hospital, Quetta, Baluchistan, India.

MAXWELL, J. L., 208, Nanyang Road, Flat 307, Shanghai.

MITCHELL, A. M., Tower House, Tower Street, Portsmouth. (Tel. 7090.)

RODGERS, H. W., 32, Holly Park, N. 3. (Tel. Finchley 5243.) 20, Upper Wimpole Street, W. 1. (Tel. Welbeck 3640.)

WILLIAMS, A. L., Hallaton Cottage, near Market Harborough, Leicestershire.

BIRTHS.

HARRIS.—On June 22nd, 1935, at 13, Lansdown Place, Clifton, Bristol, to Rowena (*née* Clarkson), wife of H. Elwin Harris, F.R.C.S.—a daughter.

HORDER.—On May 25th, 1935, at 4, Boyne Park, Tunbridge Wells, to Jessie, wife of Cecil A. Horder, M.B., F.R.C.S.—a son.

LEAVER.—On June 9th, 1935, at 35, Palace Court, W. 2, to Audrey (*née* Robinson), wife of Dr. R. H. Leaver—a daughter.

ORMEROD.—On June 21st, 1935, at 31, Broomhill Road, Woodford Green, to Margot, wife of Thomas L. Ormerod, M.B.—a daughter.

ROBSON.—On April 22nd, 1935, at Old Court, Ealing, to Edith (*née* Knape), wife of Dr. John A. Robson—a son.

ROCHE.—On June 23rd, 1935, at 7, Knaresborough Place, S.W. 5, to Cicely Mary (*née* Briggs), wife of Alex. E. Roche, F.R.C.S.—a son.

RUSSELL.—On June 6th, 1935, at 20, Devonshire Place, to Lilian, wife of Bedford Russell, 86, Harley Street, W. 1—a son.

TISDALL.—On June 7th, 1935, at Harrow, to Christina, wife of O. R. Tisdall—a daughter.

TURNER.—On June 7th, 1935, at 20, Devonshire Place, to Peggy (*née* Ingram), wife of Dr. Ronald Turner—a son.

MARRIAGES.

CRUDEN—PRIDIE.—On June 15th, 1935, at St. Mary Redcliffe, Bristol, Samuel Scott Cruden, M.D., of Exeter, to Helga Pridie, of 40, Apsley Road, Clifton, Bristol.

PROWSE—GRANT.—On June 1st, 1935, at Mickleham, Surrey, Cedric Barrington, younger son of Dr. and Mrs. W. Barrington Prowse, of Brighton, to Jean Ogilvie, younger daughter of Mr. Selwyn Grant and the late Mrs. Grant.

SODEN—JESSUP.—On June 15th, 1935, at St. Stephen's Church, East Putney, by the Vicar, Rev. Walter Southam, Dr. George E. T. Soden, only son of Mr. and the late Mrs. Soden, of Bromley, Kent, to Clara Margaret, only daughter of Mr. and Mrs. T. H. Jessup, of 12, Dryburgh Road, Putney.

TANNER—THYNNE.—On Thursday, June 20th, 1035, at St. Bartholomew's Church, Holmer, Hereford, by the Rev. R. S. Maxwell, assisted by the Rev. W. A. Timmis and the Rev. G. W. Stewart, Dr. Guy Montague Tanner, of Newton Abbot, eldest son of Mr. and Mrs. P. B. Tanner, of Woodstock Road, Oxford, to Nancy Constance, eldest daughter of Mr. and Mrs. Geoffrey Thynne, of Holmer Court, Hereford.

UNDERWOOD—BECK.—On June 1st, 1935, at St. Mary's Church, Shenfield, Essex, by the Rev. W. Lewis, William Elphinstone, elder son of Dr. and Mrs. A. C. Underwood, of Felstead, Essex, to Vera Florence, the fourth daughter of Mr. and Mrs. H. G. Beck, of " Normanhurst ", Hutton, Essex.

WILLIAMS—HOGBEN.—On May 20th, 1935, at Aldingham Church, by the Rt. Rev. the Lord Bishop of Barrow-in-Furness, Dr. Alexander Liberis Williams, of Hallaton, Leicestershire, to Dr. Frances Anne Hogben, of Kendal, Westmorland.

DEATHS.

MACKENZIE.—On June 13th, 1935, at Lansdowne House, Ryde, Isle of Wight, Kenneth Walter Ingleby Mackenzie, L.R.C.P., M.R.C.S.

MOSS.—On May 12th, 1935, Basil Eustace Moss, M.B., B.S., of 343, Fore Street, N. 9.

SHARPE.—On May 30th, 1935, suddenly while swimming at Clissold Park Baths, Archie, elder son of Rev. E. B. and Mrs. Sharpe, of C.M.S., Purulia, India, aged 20.

STUART-LOW.—On June 5th, 1935, at The Homestead, Northwood, William Stuart-Low, F.R.C.S., of 49, Wimpole Street, aged 77.

TAIT.—On June 7th, 1935, at Handcross, Sussex, Henry Brewer Tait, F.R.C.S., aged 75.

WARD.—On Friday, June 7th, 1935, in a nursing home, London, Hugh, aged 3, dearly loved son of Dr. and Mrs. Roy Ward.

WRIGHT.—On June 10th, 1935, at Crabbetts, Hoveton St. John, Bernard Duncan Zorapore Wright, M.R.C.S., L.R.C.P., aged 72.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review, should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *at the Hospital.*

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, *The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone; National* 4444.